PHYSICAL MEDICINE AND REHABILITATION GROUND RULES

1. **AUTHORIZED PROVIDERS:** Services applicable to this section are payable at the level of the Unit Value (or the usual and customary charge, whichever is less) when provided by: a health care provider as defined by K.S.A. 44-508; a Registered Physical Therapist; a Registered Occupational Therapist; a Certified Physical Therapist Assistant or a Certified Occupational Therapist Assistant when the service is performed under the direct supervision of a Registered Physical Therapist or Registered Occupational Therapist; an Exercise Physiologist; and any type of an Assistant when the service is performed under the direct supervision of a health care provider, Registered Physical Therapist, or a Registered Occupational Therapist.

2. **CONCURRENT EVALUATION AND MANAGEMENT SERVICES:** When evaluation and management services have also been provided, it is acceptable to charge separately for these services only if the patient's condition required an evaluation or examination that is beyond the usual preservice and postservice work associated with physical medicine and rehabilitation services. **Such additional services, however, shall be reported separately using modifier -25.** These services must also be performed or supervised by a health care provider as defined by K.S.A. 44-508, a Registered Physical Therapist, or a Registered Occupational Therapist. Charges for any evaluations or examinations after the initial visit must be documented and included with the bill.

3. **DOCUMENTATION OF TREATMENT REQUIRED:** Documentation of treatment shall include evaluation, diagnosis, progress notes, prognosis, treatment plan, and need for further therapy. This documentation will be made part of the patient's record and be made available upon request. This documentation does **not** warrant a separate fee.

4. **WRITTEN REFERRAL:** A written referral by a health care provider, as defined by K.S.A. 44-508, is required for services to be provided by a physical or occupational therapist, exercise physiologist, or their assistants.

5. **SEPARATE BILLING:** Employed physical or occupational therapists may not bill separately for services provided. This does not apply to physical or occupational therapists who are self-employed.

6. **DISPUTE RESOLUTION:** In the event a controversy arises between the provider and the payer about the number of modalities or therapeutic procedures that were provided at each visit, an attempt should be made by the involved parties to resolve said issue(s). Issues which cannot satisfactorily be resolved should then be referred to the Kansas Division of Workers Compensation for review.

7. **MAXIMUM NUMBER OF VISITS:** Treatment beyond 21 visits must be authorized by the employer, the insurance carrier, the Workers Compensation Fund, or the Kansas Division of Workers Compensation, unless prior authorization was received for a greater number of visits.

8. **FOLLOW-UP OR AFTERCARE:** Fees for any follow-up or aftercare for fractures, dislocations, or postoperative procedures provided by physical or occupational therapists shall be in addition to those payable to the referring health care provider.

9. **HOME SERVICES:** When an authorized provider renders treatment in a patient's home, the Unit Value may be increased by 50%. An explanation substantiating the need for home therapy shall be submitted along with the bill.

10. **UNLISTED SERVICE OR PROCEDURE:** When an unlisted service or procedure is performed, the procedure should be identified and the amount charged substantiated "by report" (BR). Unlisted service or procedure codes usually end in "99."

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11. PROCEDURES LISTED WITHOUT A SPECIFIED UNIT VALUE: "BR" in the Unit Value column indicates that the amount charged for this service is to be determined "by report" because the service is too unusual or variable to be assigned a Unit Value. Pertinent information should be furnished concerning the nature, extent, and need for the procedure or service, the time, skill, and equipment necessary, etc.

12. SEPARATE PROCEDURES: Some procedures are commonly carried out as an integral part of a total service, and do not warrant a separate identification. When such a procedure is performed independently of other services to which the procedure is not immediately related, the Unit Value for the "separate procedure" listing, where identified as such in the Schedule, is applicable (i.e., when a procedure which is ordinarily a component of a larger procedure is performed alone for a specific purpose, the component procedure may be considered to be a separate procedure).

13. CONCURRENT CARE: When the condition of the patient requires the skills of two or more health care providers to treat different conditions, payment is due each health care provider who plays an active role in the treatment program. The services rendered by each health care provider shall be distinct, identifiable, and adequately documented in the records and reports.

14. ALTERNATING HEALTH CARE PROVIDERS: When health care providers of similar skills alternate in the care of a patient (e.g., partners, groups of same facility, covering providers on weekends or vacation periods), each health care provider shall charge individually for the services personally rendered and such charges shall be in accordance with this Fee Schedule.

15. PRORATION OF UNIT VALUE: Where the schedule specifies a unit value for a definite treatment, and the patient is transferred from one health care provider to another, the Unit Value stated in the Schedule or the usual and customary charge, whichever is less, should be apportioned between or among the providers. The providers involved shall agree upon the amount of proration, and shall render separate bills accordingly, with an explanatory note.

16. ADD-ON CODES: Certain codes, by the nature of their description and the unit values assigned, have already been reduced, as they are not to be billed as primary procedures. For a complete list of the codes which are considered to be add-on codes, refer to the appropriate appendix found within the most recent publication of the **AMA Current Procedural Terminology (*CPT*)**.

17. MISCELLANEOUS: The Unit Values for other diagnostic therapeutics, anesthesia, surgery, x-rays, and laboratory procedures are listed in the following sections: Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine, and Evaluation and Management. Physical or occupational therapists may utilize these other sections for billing if the coding is more appropriate, and the service provided was medically necessary and prescribed by a physician.

18. CONSULTATIONS AND REFERRALS: A **consultation** is a service rendered by a specialist at the request of the attending health care provider or other appropriate source seeking further evaluation or an opinion on how to proceed in the management of a patient's illness. Consultations always require a narrative report from the consultant to the attending health care provider requesting the opinion. The fee payable should correspond appropriately to the level of service. When the consulting specialist assumes responsibility for the continuing care of the patient, any service rendered subsequent to the consultation will be reimbursed according to the actual level of service rendered, as listed under the appropriate subsection headings (e.g., office or hospital visits).

A **referral** is the transfer of a patient to a specialist for diagnosis, and where necessary, treatment of a specific illness or injury, rather than for advice. A referral will be reimbursed according to the actual level of services rendered, as listed under the appropriate subsection headings (e.g., office or hospital visits).

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19. **FAILURE OF PATIENT TO KEEP A SCHEDULED APPOINTMENT:** In the event a patient fails to keep a scheduled appointment, the health care provider is not to bill for any services that would have been provided by said appointment nor shall there be any reimbursement for such scheduled services (i.e., reimbursement for a "no show" appointment is not allowed). This rule does not apply with regard to a deposition, testimony, or IME.

20. **MODIFIERS:** Appendix A - Modifiers of this Schedule includes all of the modifiers applicable to the current *CPT* codes.

21. **COST CONTAINMENT:** Nothing in this section shall preclude an employer (or insurance carrier) from entering into payment agreements to promote the continuity of care and the reduction of health care costs. Such payment agreements, if less, will supersede the limitation amounts specified herein. Please refer to K.S.A 44-510i(e) for further clarification, if necessary.

CONVERSION FACTOR = $43.80

PHYSICAL MEDICINE AND REHABILITATION

(CONVERSION FACTOR = $43.80)

CODE	UNIT VALUE
97001	2.00
97002	1.06
97003	2.14
97004	1.29
97005	1.62
97006	0.81
97010	0.12
97012	0.39
97014	0.38
97016	0.37
97018	0.17
97020	0.13
97022	0.39
97024	0.14
97026	0.13
97028	0.16
97032	0.42
97033	0.54
97034	0.37
97035	0.32
97036	0.61
97039	0.31
97110	0.74
97112	0.78
97113	0.85
97116	0.65
97124	0.59
97139	0.42
97140	0.70
97150	0.46
97504	0.81
97520	0.74
97530	0.78
97532	0.65
97533	0.69
97535	0.79
97537	0.72
97542	0.74
97545	3.22
97546	1.29
97597	1.29
97598	1.64
97602	0.47
97605	BR
97606	BR
97703	0.68
97750	0.79
97755	0.92
97799	BR